AmeriHealth Insurance Company of New Jersey
AmeriHealth HMO, Inc.
8000 Midlantic Drive ▪ Suite 333
Mt. Laurel, NJ 08054

AmeriHealth
NEW JERSEY

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

GROUP NAME

GROUP POLICY NO

EMPLOYEE NAME

Last First M.I.

SOCIAL SECURITY #

DATE OF BIRTH Month Day Year

DATE OF HIRE Month Day Year

MARITAL STATUS ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced**

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by Amerihealth.

I REFUSE the following:

- ☐ Employee, Spouse and (Child(ren) Coverage
- ☐ Spouse Coverage
- ☐ Child(ren) Coverage

REASON FOR REFUSAL (Please indicate all that apply.)

- ☐ other group coverage sponsored by my employer
- ☐ other group coverage sponsored by my spouse's employer
- ☐ other group coverage sponsored by another organization
- ☐ other-reasons--please explain

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Please provide name of carrier and policy number.

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I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form, and coverage may be subject to a pre-existing conditions exclusions.

Signature of Employee ______________________________ Date ______________

Signature of Witness ______________________________ Date ______________

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